THE MEDICAL FORTNIGHTLY

Vol. XXXVIII ST. LOUIS, FRIDAY, NOVEMBER 25, 1910. No. 10

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LEADING ARTICLES

THE POSTOPERATIVE CARE AND TREATMENT OF SUPRAPUBIC PROSTATECTOMY.*

D. W. BASHAM, M. D.

WICHITA, KAS.

The after-treatment of a simple celiotomy consists mainly in placing the patient comfortably in bed and allowing him to get well. This is especially so since we have discovered through overuse and abuse of the various hypodermic medicaments that they are more harmful than helpful.

Suprapubic prostatectomy offers a pronounced exception to the expectant plan of post-operative treatment. The fact is that the after-treatment is fully as important as the operation itself. Many cases would die or fail to recover with full functionment of the bladder without suitable treatment during convalescence from the operation.

Suprapubic prostatectomy should not be performed outside the hospital unless an experienced male nurse can be left with the case to attend to the details of the after-treatment. Freyer, the English genito-urinary surgeon who has done more to advance our knowledge on this subject than any other man living or dead, insists with emphasis upon the importance of the after care of these cases.

*Read before the fifth annual meeting of the Medical Association of the Southwest at Wichita, Kas., October 12, 1910.

Most of these cases come to us in an enfeebled condition brought about by years of catheter life with infection of the bladder accompanied with pain and vesical tenesmus. Frequent attacks of urinary stasis may have resulted in an ascending pyelitis. These conditions may all be aggravated by prolonged and crude efforts to pass the catheter. It is possible for pyelitis to be provoked after the operation provided the drainage is not absolutely unobstructed. Drainage is indispensable in most cases of suprapubic prostatectomy. There are a few cases in which the bladder may be closed and urethral drainage depended upon, but they are not numerous and constitute the exceptions to the rule of safe practice.

Many forms of drainage have been employed some of them with the object of keeping the patient dry much as we do in operations upon the gall-bladder, but it has been found that the simpler forms of drainage are the best. The rubber tube having a diameters of not less than half an inch, fenestrated toward the end, and having the edges pared to a feathery thinness constitutes the best means of drainage. If the tube be even larger in caliber it is still better. The large tube permits of the removal of coaguli from the field of operation which are often the source of great pain and cause of vesical tenesmus. Hemorrhage may be treated and controlled through a large tube. The method of placing the drainage tube is important. Neither the drainage tube nor the bladder should be stitched to the abdominal parietes. If the bladder be stitched to the walls of the abdomen and unite there the viscus will not be able to evacuate its contents even after healing, and if the stitches become infected, as frequently occurs, an unnecessary complication and danger is added to the case. The tube should not penetrate the cavity of the bladder more than an inch. It should be anchored by a stitch on each side to the margins of the bladder wound and left freely movable in the abdominal wound. In this way there is no tugging on the tube when the patient shifts his position in bed, coughs, or has a bowel movement. The vesical extremity of the tube cannot become displaced from the bladder, and thus fail of its intended function. The stitches which secure the tube inthe bladder must be entirely removable without undue traumatism that no foreign

substance be left behind to act as a nidus or stone. The drainage must be perfectly free and unobstructed at all times during convalescence because urinary stasis on account of a clot in the drainage tube might give rise to ascending pyelitis or aggravate a latent infection of the upper urinary tract. At each dressing the tube should be inspected and any clots that may have formed should be removed with a long slender forceps for the purpose. If there is hemorrhage or free oozing from the field of operation it may be arrested by simply dropping twenty drops of a 1-1000 solution of adrenalin into the cavity of the bladder through the drainage tube every three or four hours as long as necessary.

Some of the failures are due to infection of the cellular tissue in front of the bladder. This accident is best prevented by gauze drainage in front of the tube carefully placed so as not to depress the bladder and thus increase the depth of the Cavum Retzii.

The space in the upper part of the wound is treated in the same manner. These gauze drainages are removed on the second, third or fourth day. In the obese they are allowed to remain longer than in thin patients.

If the operation be followed by shock normal saline should be administered per rectum by the Murphy method. At the same time dry heat should be applied to the extremities and about the patient's body. The hypodermatic exhibition of extract of the posterior lobe of the hypophysis cereberi is serviceable in the presence of shock and so also is adrenalin. I direct twenty drops of adrenalin to be instilled into the bladder through the drainage tube every four hours as long as there is any considerable amount of oozing of blood.

In suprapubic prostatectomy the rectum is generally uninjured so that clysters of coffee or other substances may be employed. It may be remarked that shock is rare after transvesical prostatectomy. If the drainage tube is not placed too deep in the bladder, and in such a manner that the end does not impinge upon the field of operation pain is usually not severe after the operation. Obstruction of the drainage causes distension of the bladder, and consequently gives rise to pain. The accident may also provoke an ascending pyelitis. There is no objection to the moderate and guarded use of codeia or morphia if the pain is severe. Aspirin is a valuable agent with which to combat pain and restlessness after the operation and should be given instead of morphia as soon as gastric medication can be employed.

The bowels may be opened on the second, third or fourth day according to the condition of the patient. Food may be allowed on the second, third or fourth day as after celiotomy. For the first three or four days when the drainage tube is still in place the bladder may be washed out daily through its lumen. After the drainage tube has been removed, which is usually on the third or fourth day, the bladder may be cleansed through the suprapubic wound until the lapse of a week or ten days. After this the irrigation may be made per urethram either with or without the use of a catheter, better however without. The urine may be expected to pass by the urethra any time after five or six days. It is better for these patients to get out of bed early. This facilitates both drainage and the early passing of the urine per urethram. If there is pyelitis the erect position favors drainage and may serve to avert the extension of the disease. Orchitis sometimes occurs and constitutes a disagreeable complication of the convalescent stage. This is best prevented by supporting the testicles with some form of suspensory apparatus.

In many of these cases the walls of the bladder have been so long diseased that the urine is acrid and more or less infected. This acrid urine flowing over the abdomen often causes an erythema and sometimes severe excoriation. Zinc oxide paste is one of our best means of preventing this complication.

There is a tendency for the earthy salts to be precipitated from the urine and settle in the wound both in the walls of the abdomen and in that part of the bladder where the prostate was removed. One of the simplest and most efficient means of preventing this is the administration of sodium benzoate continuously for a number of days. The patient should drink abundantly of distilled water.

Healing of the abdominal fistula usually takes place readily and without special difficulty. Sometimes, however, the tract fills up with indolent granulation tissue and it becomes necessary to remove the offending tissue with a curette or to destroy it with silver nitrate.

Occasionally there may be a case where cicatricial contraction takes place in the scar structure at the neck of the bladder which may need to be divulsed with the sound. If sounding is indicated I do it; if not, I let the patient get well without it. A fatal issue is nearly always due to pyeli-

tis, nephritis, or some coexisting pathologic condition and not to the operation itself.

(See discussion, page 469.)

PYLORIC OBSTRUCTION DUE TO EXTRINSIC CAUSES.

GORDON A. BEEDLE, M. D.

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In reporting the following cases embraced in this article, the chief purpose is to bring before you for consideration the demonstrated importance offered by adhesions towards the productions of pyloric obstructions. Considering the anatomical intimacy of the pylorus with that compact area in the right hypochondrium, composed of the gall bladder, ducts, pancreatic head, and duct, receiving portion of the duodenum, associated involvements resulting from inflammatory lesions of this frequently invaded field are clearly conceivable. When we consider the varied and extensive symptomatology of stomach trouble generally termed indigestion and appreciating the fact that this indigestion is so often a sequence or adjunct to various other lesions such as appendicitis, gall-stones, etc, obscurity in diagnosis is often made possible.

The increased realization of the frequent occurring chronic stomach trouble dependent for its relief upon some surgical intervention on organs directly or indirectly associated, is essential evidence that we cannot bear too much stress upon more intimate and close association of the surgeon and stomach internist, thus broadening the view at the operable stage of dawning malignancy gall bladder involveness, adherent appendicitis, adhesions, cecal involvement, etc.; on the other hand, importance of surgical recognition of the valuable assistance bestowed by the internist through laboratory and chemical findings of stomach, stool and urinary contents aided by various additional procedure of diagnosis; with finally the clinical judgment of both united in conference. However an exhaustive treatise could but sparingly cover the importance of close intimacy between the surgeon and internist in cases of obscure stomach conditions.

The following is the history of a case of Mr. W.; farmer; referred by Dr. Niensted of Le Loup, Kansas; age 36; weight 135 lbs; regular weight 146 pounds; height 5 feet 10 inches; parents both living. Father troubled with slight stomach trouble, ten children in family all living, and healthy, but one brother who complains with similar trouble of stomach but not constant or severe. Patient's period of ill health commenced about twelve years ago, or at the age of 24. Attacks beginning with pain in stomach belching large quantities of gas, attacks occurring two or three hours after eating, relief afforded by the taking of food or by free emesis. Constipated at time of attacks, constant attacks recurring frequently for two or three days when with through elimination, and dieting, condition would gradually subside into normal state and continue so for several months. Blood never observed in emesis or stool, no appearance of jaundice. Early history of sour regurgitation at time when stomach is empty. Typical history of attacks continued the same over a period of years. Pain always localized and tenderness limited to the epigastrium, growing, however, in frequency of its periodicity and severity. About three years ago obtained complete relief after receiving medical treatments by his home doctor. The period of freedom lasted about two years, when similar attacks commenced again continuing until the time of his operation during past two months distress almost constant. Saw patient June 14th, 1910. General history as presented above, tenderness over the epigastrium and right hypochondriac regions. Stomach dilated, peristaltic contraction of stomach wall, on stimulation, pain increased on traction upward of left thorax during inspiration, rigidity of the upper right rectus; referred to Dr. Roberts for stomach analysis which was as follows: Test meal, total quantity 450 c.c.; total acid 66, free H.C.L. 40 to 14 per cent; finely divided fluids in great excess, small amount of mucus, starch; digestion good; no sarcinae Oppler Boas; yeast fermentation profuse; duration test, positive two quarts; diagnosis obstruction at pylorus of benign type.

Operation. — Stomach exposed cardiac half of the stomach free, pyloric half of the stomach appearing congested. The pylorus pulled high up under the liver and held firmly in a cramped position by extensive adhesions a slightly thickened area in stomach wall of the pyloric half of greater curvature about one inch long and one half inch wide, but did not extend to the pylorus. Gall bladder seemed free of adhesions and normal in appearance. The epiploic vessels greatly enlarged and hard, the omentum was involved in the mass

*Read before the Medical Association of the Southwest, Wichita, Kansas, October 11, 1910.

of adhesions. No glandular enlargement detected. The abdomen was opened in this case for the purpose of performing a gastro-jejunostomy for obstruction of the pylorus, evidently resulting from healed pyloric ulcer, after thorough intra-abdominaly examination the kinked position of the pylorus, the same being bound down by adhesions and the evident freedom of scar tissue in the pyloric lumen made conservation seem the proper procedure after careful freeing of all adhesions we decided to postpone the anastomosis, doing the same later if present efforts were not sufficiently successful. Post-operative convalescence was all that could be desired, one lavage following the operation; liquid diet for three days followed by light diet and general diet at the end of first week. No pain after third day following operation. General post-operative attention was accompanied by rapid improvements; left hospital at the end of two weeks with every appearance of complete relief from his trouble. It being four months since operation I was pleased to receive a recent report from this patient, stating that there had been no return of his previous trouble, increasing in weight and enjoying good health in general.

In my opinion, this case represents a much larger class of stomach sufferers than we have been inclined to recognize. When we consider the large percentage of stomach ulcers properly treated medicinally and healed never having developed the surgical stage such as extravagant hemorrhages, perforation, etc., proceeding for a varying length of time with apparent freedom in symptomatology, with distress of less severity, obtaining temporary relief, but discouraged from the repeated recurrence, he begins shopping from one doctor to another, confidence fluctuating in a comparative degree to the medical relief obtained. So may a case of this character bounded in obscurity of its acute etiology, travel on for years under the head of gastric neruosis, gastric catarrh, etc., fortunate is this man should he fall in the hands of the thorough up-to-date internist of today who isolates and differentiates through repeated findings, and if the case be deemed necessary will promptly recommend surgical interference or in obscurity will advise exploratory incision.

Mr. B., of Marian, Kansas. Recommended by Dr. Sanders, of Rosedale, Kas. History taken by Dr. Sanders, April, 1908. Male; age 28; single; 5 feet 11 inches; weight 130 pounds. Family history good; past history good, with exception of an attack of indigestion several years previous, occurring periodically about once a month, apparently free from same, however, for the last year or two, run until about October, 1907, when similar symptoms returned; attacks would begin by headache, vertigo, belching of gas vomiting, large quantities of sour fluids, no blood, pain in epigastrium extending around to the upper lumbar region on the right side, distress and acid eructations coming on frequently in the early morning hours. Some relief after emesis, stubborn constipation always constant at time of attacks, stool matter lumpy and light in color during attacks, but months, no blood apparent. Patient treated medicinally for these attacks during the past six months with but temporary benefit. Attacks becoming more frequent and severe in character. Patient developed severe attacks Feb. 9th, 1910. When first seen by Dr. Sanders temperature 103, pulse 110, severe pain over epigastrium extending over right side slightly jaundiced, constipated, vomiting large quantities of sour fluid, urine containing bile, leucocytosis 18,000; muscular rigidity over upper right abdomen had been unable to retain anything in stomach for several days; jaundice increased markedly during the next twelve hours, patient growing apparently weaker. Stomach analysis normal, but showing increased quantity. Gall bladder incision February 12, 1910. Gall bladder pouted into the wound when abdomen was opened, dilated and thin walled adhesion extensive, bladder drawn upon top of liver about one and one-half inch and plastered there with adhesion. The colon adherent to the inferior surface of gall bladder after freeing same we found adhesions more dense as we neared the duct. The pyloric end of the stomach was drawn over towards the gall bladder and extensively involved in adhesions, no abnormal appearance in stomach wall except general congestion of vessels with general enlargement of the organ. Adhesions were freed and gall bladder opened and explored for stones, none were found. The bladder contained large quantities of extremely thick black bile, gall bladder drained and incision closed. Patient improved rapidly with no recurrence of pain or vomiting. Digestive functions apparently normal on leaving the hospital. A recent communication from Dr. Sanders states that patient has had no return of his gastric symptoms, and is in excellent health. This in my opinion was an operable gall bladder case, but adhesions impining the pylorus as a result of his long

standing cholecystitis was the chief cause of the man's gastric discomfort for years. The anatomical distortion discovered on intra-abdominal exploration in this case demonstrated clearly the extensive scope that adhesions secondary to gall bladder infections can play towards the production of obstruction at or near the pylorus, bringing before us for consideration the frequency of such a complication associated with gall bladder lesions, or more important, the possibility of the frequent obstructive influence of such adhesions resulting from mild inflammatory attacks of the gall bladder. It appears to me a safe conjecture that a great many chronic obscure gastric disturbances can be traced to this latter conclusion. The tendency of some individuals towards the rapid formation of abdominal adhesions, the close antaomical association of the organs in question and the frequent recuperation of acutely infected gall bladder, regaining and maintaining a normal condition, all bear witness to the plausability of the conjecture above, at least placing the same before us (as worthy of thought in formulating a diagnosis), the possibility of adhesions being a prime factor in all cases bearing the symptomatology associated with the gastric obstruction. The following case of Dr. Wise, operated on at Carthage, about a year and a half ago, seen but once before operation, history meager. Widow, between 55 and 60 years old. Family history good, no tuberculosis, no cancer, had enjoyed good health all her life with exception of last few years, had been troubled with dyspepsia, attacks of same coming about ten years ago, at that time being mild in character, consisting chiefly of distress after eating, with belching of gas and slight distention, attacks would last a few days then pass away for a month or two, attacks gradually become more frequent, accompanied with nausea and vomiting became an early factor; no blood in emesis, but quantities of acid fluid frequently containing particles of food eaten the day before were noticed; slight chills with fever occurred at times; jaundice developed during later attacks; stool light and constipated; urine normal.

Examination of Case.—Patient extremely fat and slightly jaundiced. Temperature 102, complained of cutting pains throughout right hypochondrium and epigastrium extending through to back or right side, opposite lower thoracic vertebra, tongue coated, nausea and vomiting, stomach distended, elicited no peristaltic wave on massage; extension uwpard and backward of left arm caused maternal increase of pain tenderness; diffuse over epigastrium, diagnosed gall stones, complication with adhesion involving the stomach and advised operation. Incision revealed a mass at site of the gall bladder, which proved to be a reflected portion of omentum containing hard callarium mass of tubercular deposit, wedged down on the gall bladder and adherent in every direction. Careful exsection revealed the pyloric half of the stomach drawn down and firmly anchored, tumor pressure and malposition caused by ahesion, clearly defining the cause of the obstructive symptoms, there was a slight amount of fluid in the cavity, and a few scattered tubercles could be felt on the peritoneum, the gall bladder all through slightly dilated and full appeared normal and was not opened; this patient recovered with complete freedom of her previous symptoms, in good health six months after operation. In this case, had a stomach analysis been made the findings no doubt would have strongly indicated obstruction with dilatation and motor insufficiency, but arrival at the actual cause could be made positive only through incision. The tuberculous invasion of long standing with adhesion development from early perigastric irritation, most probably accountable for early disturbance of gastric function.

Differential diagnosis of constructive adhesions of this character their responsibility as a complete or partial factor in the production of symptoms may present a picture of comparative clearness or dense obscurity. Valuable as a chemical analysis are, there are times that they fail to bear out or confirm a diagnosis based upon physical examination and clinical history. The stomach may develop an atonic stage early under obstructive influence, and not develop the beginning muscular hypertrophy which is frequently an early compensation associated wtih dilatation, in such a case the customary findings of the increased amount of gastric secretion would be absent, in the connection with the same Hcl may be diminished or entirely absent, thus while being due to extrinsic obstruction the stomach findings may suggest that of an a tonic dyspepsia, or the absent Hcl finding taken alone point towards malignancy, again as the various degrees of involvement exist may we expect complicating variations which may or may not coincide with a clinical and physical finding, fully as possible does confusion occur from the clinical and physical aspect, the pylorus in normal position under the crest of liver is inexcessible to palpation while with dilation

the pylorus with movable portion of duodenum is drawn downward permitting more successful palpation, which may reveal the bubbling sensation to the palpating fingers at the constricted pyloric passage, in this position may be distinctly evident the peristaltic wave of contracting stomach muscles brought on by stimulating massage over the surface of the epigastrium, this sign is present in many cases of obstruction, but may be absent or not apparent if obstruction be due to adhesions a diagnostic sign which I have found of frequent existence is a drawing pain radiating through the right hypochondrium during extension upward and backward of left arm, thus drawing up on left shoulder and thorax; in cases of stenosis or obstruction unaccompanied by ulcer or cancer, sharp pain may occur after the intake of food or associated spamodically with a peristaltic contraction of the stomach wall, especially in cases where the involvement has reached an extreme gastritis, this symptom, however, is rare and is more commonly asssociated with stenosis accompanied with ulcer or carcinoma; failure at obtaining relief after emesis or continued and frequent vomiting with pain after the stomach is emptied, is strongly indicative of advance gastritis with accompanying lesion, in such cases important aid in differentiation should be acknowledged through chemical analysis and microscopical findings.

428 Altman Building.

The New Tuberculosis Directory of the National Association for the Study and Prevention of Tuberculosis, that will be issued soon, will list over 400 sanatoria and hospitals with a bed capacity of nearly 25,000; more than 300 special tuberculosis dispensaries and fully 450 anti-tuberculosis associations and committees. Since the first directory was issued in 1904, the increase in the number of agencies fighting consumption aggregates nearly 500 per cent. It will contain up-to-date lists of all hospitals, sanatoria, dispensaries, and associations engaged in the war against consumption. A summary of what has been done by the various State legislatures, and the county and municipal governing body will be included in the book. It will be the most complete report of the anti-tuberculosis campaign that has ever been published in this country.

LEA FOR CONSERVATIVE SURGERY.*

HOWARD D. EATON, B. A., M. D.

CHIHUAHUA, MEXICO.

The evolution of surgery during its brief but spectacular career since the days of the immortal Lister and Pasteur has established the axiom that "Surgery which conserves is the highest type of surgery." Too often is it still true that surgeons have to mutilate the part in order to preserve the whole.

As a contribution to the science of conservation I am glad of the opportunity to put on record the following case: On the 25th of September, 1909, I was called to see a 16-year old girl who, eight days previously had had her skirts caught in the fly-wheel of a gasoline engine, and a few minutes later was found lying in the corner of the room almost unconscious, with nearly every stitch of clothing torn from her, with a fractured clavicle, and in a pool of blood from a most severe crushing and cutting injury to her left foot and ankle. It looked just as if a butcher had tried to cut off the foot with his cleaver and had made a poor job of it, cutting and splintering the external maleolus and almost severing the entire foot in a horizontal line passing through the middle of the external maleolus, cutting off the lower end of the calcaneum and into the upper half of the cuboid. Enough of the tendons, however, had been left to allow motion of the toes. A Mexican doctor had been called in and had sutured the skin and muscles with catgut. By the third day he had a badly infected foot to worry him and had to take out the stitches and give daily antiseptic treatment to the wound. In order to be more thorough he allowed it to flap open during the process, cutting off fragments of dead flesh with his scissors and causing the poor girl such exquisite pain that her screams were heard a block away. The foot seemed to be attached by skin and flesh only and each day the doctor became more insistent that there was no alterative but that of amputation, especially as the patient was developing a typical condition of general sepis, alternating irregular chills and high fever. The poor girl was an orphan and had only a sister two years older, for a nurse and guardian, but they steadfastly objected to an amputation at least without a consultation, to which the attending doctor at last gave a reluctant consent. A local German surgeon was accordingly called and after examining the

*Read before the International Medical Association of Mexico, El Paso, Texas, October 28, 1910.

foot gave his opinion, that with great care and patience the foot could be saved. He and Dr. X. had a rather stormy interview in a room by themselves during which Dr. Y. criticized Dr. X.'s method of treatment somewhat severely in his brusque German way, though they were good friends and he did it in a spirit of helpfulness. Dr.X. then washed his hands of the case, both literally and figuratively, and Dr. Y. refused to continue with the case as the former's successor on the safe and justifiable ground that it would be unprofessional and would open him to critiscism on the part of his colleague.

The patient having been left without any medical attendant in a dangerous state of septicemia, after all the circumstances had been carefully explained to me, I agreed to see what I could do for her, merely from a scientific as well as a humanitarian interest, and not from any hope of pecuniary reward,. Accordingly with the help of a practical American nurse (the patient having refused to go to a hospital) under chloroform anesthesia I cleaned the wound as thoroughly as was possible under the very unfavorable circumstances. One thing we did have, and that was plenty of light, as we operated in an upstairs room with a wooden floor—two unusual conditions in old Mexico. We used plenty of bichloride to wash away the abundant pus, curetted all the unhealthy granulation tissue and the fractured surfaces of the os calcis and removed several small splinters of bone. I was not equipped to suture the calcaneum with either wire or kangaroo tendon so I merely coaptated the fragments as closely as possible with deep silk sutures through the flesh. As I knew it was impossible to secure an absolutely aseptic wound I filled the cavity with balsam Peru just previous to completing the suturing—a medicine that I have become very fond of in all contused wounds where it is hopeless to secure aspesis on account of in-ground dirt and grease—and I bandaged with a card-board splint, not feeling at all sanguine as to the outcome.

The next morning the patient was much better, with hardly any fever or pain and had passed a fairly comfortable night. The next day after cleaning the wound with peroxide of hydrogen and covering it with balsam Peru, I applied a fenestrated plaster of paris bandage. The foot was dressed daily by either the nurse or myself for about two weeks after which every third day for a like period and then once or twice a week until entirely well. For the first few days there was considerable suppuration, but it diminished until at the end of two weeks it had almost ceased. On the third day after the operation the temperature had again risen to 40 deg. C. with a pulse of 120, but two days later it had dropped to 36.8 deg.; pulse 100 and continued subnormal, reaching 36 deg. before finally returning to normal. Five days after the operation I had to insert an iodoform gauze drain across the front of the ankle and one into the center of the wound. Three days after putting on the cast the swelling had gone down so much that I had to remove it and apply a new and lighter one.

On September 30th or fifteen days after I took charge, the wound had almost closed, there was hardly any pus, no fever or pain, the patient had a good appetite and was feeling fine. It was about nine months before the two or three small superficial ulcers that remained finally healed over after a minute spicula of bone was discharged. At present, thirteen months after the original injury the foot has been entirely healed for four months, and although the ankle is quite stiff the patient is able to walk on it with only a slight limp and is again at work.

Conclusions: (1) When in doubt whether to amputate give the patient the benefit of the doubt and spare no effort in trying to save an injured limb. (2) Silver wire is not essential. (3) Balsam Peru is a very useful remedy. (4) Patience and mild antisepsis will accomplish wonders.

When seeking the cause of an obscure or indefinite abdominal pain, and especially of a pain in the loin, make a careful microscopic examination of the centrifugalized urine. Renal calculi sometimes cause only mild, irregular pains, and the finding of a few red blood cells in the urine may be the first clue to their presence.—Amer. Jour. of Surg.

Illegitimacy in France.—Perhaps with a view to discouraging illegitimacy, which is very common in France, laws were passed which deprived the child of the father's support. It has been discovered that as a result of this policy the death-rate among illegitimates is remarkably high, because of inadequate support. Now the law is being changed to make the father in all cases responsible for the support of his child. France is attempting now to raise a larger proportion of her children, even if they can not present a stainless pedigree.

A GREAT OPPORTUNITY FOR PHYSICIANS AND TRAINED NURSES ON THE FOREIGN FIELD.

In a recent number of the New York Times a physician practising in Greater New York states that the whole trouble with the profession of medicine is that it is overcrowded. "There are more physicians in Greater New York than in all the rest of the State, and five times more than in all Connecticut." He goes on to give figures and reasons why this city is overcrowded with doctors "There are entirely too many hospitals in New York. One-half the number would be plenty."

What is true of New York City is true in a large degree of our whole country, especially if compared with the terrible destitution and need in other lands. In this country there is one physician for every five hundred and seventy people, while on the foreign field there are whole regions without a hospital and millions that suffer and die without scientific medical skill or care.

The opportunities for medical work on the foreign field from a purely professional standpoint of are unparalleled. A woman graduate of the University of Toronto went out to Arabia five years ago, and after a fortnight in the only hospital along a coast of a thousand miles in this pioneer field wrote:

"During my two weeks here we have had twenty operations on the eye, one amputation, the removal of a large tumor, and numerous teeth extracted. In medicine we have had pleurisy, pneumonia, tuberculosis, tetanus, smallpox, leprosy, paraplegia, different varieties of heart-lesions, and other interesting cases. In gynecology we have the usual run of inflammations and displacements, with atresia for a specialty. One of the peculiarities of the people here is that they never present themselves for treatment until the disease is far advanced, but of course there is an excuse for them in some cases, as they may have suffered for years before there was a hospital to come to. About 75 per cent of the people seem to have eye trouble of some sort. Trachoma, trichiasis, ulceration and opacity are the commonest forms; yet inside a week one meets everything from simple ophthalmia to panophthalmitis. In fact, one would have to be a specialist in every branch of medicine and surgery to do justice to the amount and range of material which presents itself."

A trained nurse has a wonderful opportunity not only along professional lines but as a teacher of hygiene and ordinary care of the sick, as one who can train the natives to become nurses, and so help to overcome the stupendous ignorance and grovelling superstition that prevail so widely in Oriental lands.

The medical missionary and the trained nurse, however, are needed on the foreign field not only in their professional capacity, but because they are able to overcome prejudice, to open doors for the message of Christ and to incarnate that message in a way which is absolutely superior to that of the preacher or the teacher. There is a language which the whole human race can understand and which carries a message that every one, sooner or later, desires to hear. The medical missionary is master of this unspoken tongue of the heart. He is welcome in the home of the stranger. The fanatic Mohammedan allows him in the innermost harem; the mandarin calls him to his palace and the Brahmin leads him into his home. For the Christian physician and the trained nurse there is no chance to invest life that can compare for a moment in influence and power with that on the mission field. As Dr. Post says:

"You take the Bible to the heathen and he may spit upon it, or burn it or throw it out as worthless. You preach the Gospel to him and he and he may regard you as an hireling who makes preaching a trade. He may meet your arguments with sophistry; your appeals with a sneer. You educate him and he may turn from a heathen to an infidel, but heal his bodily ailments in the name of Christ, and you are sure at least that he will love you and bless you and all that you say will have for him a meaning and power not conveyed by other leaders."

The work of medical misisons in the four hundred hospitals and seven hundred and eighty-three dispensaries which are already established on the foreign field from Greenland to India and all the way across, with six million out-patients, is its own justification.

The different missionary societies are now calling for more than fifty physicians, men and women, and twenty-six trained nurses.

Particulars regarding the work, qualifications, terms, etc., may be secured from Mr. W. B. Smith, acting candidate secretary, 125 East 27th street, New York.

In suppression of the menses, cotton-seed oil, in dram doses daily, is stated will seldom fail to restore.

THE MEDICAL FORTNIGHTLY

Issued Tenth and Twenty-Fifth of Every Month

THOMAS A. HOPKINS, M. D, Editor

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EDITORIAL

The Death of a Man.

Some three years ago it was our privilege to be introduced by letter to a man living in Philadelphia, a physician who was, we were informed, hindered by physical disability from performing the arduous duties of his calling and who wished to occupy the energy of a more than usually active mind. Since that time the readers of the Fortnightly have been privileged to read the abstract work of Dr. C. W. Hepburn and they know well of its scholarly character; what they do not know is under what almost prohibitive conditions the work was done. The editor of the Fortnightly has enjoyed and been benefited by a correspondence with Dr. Hepburn which opened with the beginning of the acquaintance and has been increasingly of an intimate character as time has passed up to the time of his death, which occurred on November 3d. In spite of the fact that Dr. Hepburn was one to studiously ignore self and devote himself to others in what he wrote it was impossible to exchange letters with him and not gain a tremendous respect for the man and admiration for the brilliancy of his mind; of himself we never got one word except in unavoidable response to a direct inquiry. Such inquiry developed that he was terribly crippled by arthritis deformans, so crippled that he could not walk or stand without support, crippled in his arms and hands so that writing had to be relearned and was accomplished with difficulty; on top of this there was occasional exacerbations of the trouble in acute form during which his suffering was keen and each left him somewhat worse off. Yet his mind was not affected and his courage and cheeriness were an inspiration to those who knew him. He delighted in work and in the development of friendliness; to him friendliness meant the giving of good will and encouragement rather than being simply receptive. Though more than ten years out of the active running he had kept fully abreast with medical progress, and was as well read as any man who is constantly putting new ideas to practical test. In spite of being the victim of one of the diseases which the profession still finds baffling he never lost confidence in the art, and was a firm believer that it is a science which is doing great things and which is to do greater things. He was an optimist of the best type.

Since his death we have learned the things which we wish that we might have known while he was still with us for they increase our admiration for his indomitable courage. He was long a man of vigorous health, tremendous activity and distinct ability; doing and enjoying a large and remunerative practice; surrounded by a loving family and appreciative clientele; blessed with a degree of wealth just short of affluence. He lost all these except the able mind which made him what he was to the time of his death. Many a man would have rebelled against such apparent injustice; would have been tempted sorely to "curse God and die." But not so Dr. Hepburn. His was not the philosophy of giving up or losing faith and whatever he may have lost he kept the best so long as the breath of life was in him, and we are pleased to believe that he *still* has it.

In the death of Dr. Hepburn the editor of the Fortnightly is deeply bereaved. He was that type of Christian gentleman which is all too seldom found. He was a helpful, cheering, inspiring friend.

A Needed Change in Our Society Election Scheme.

When the St. Louis Medical Society adopted its present plan of conducting elections it was generally felt that at last a really ideal scheme had been evolved; the plan is for two ballots, the nominating ballot is sent out early in November and has blank space for the name of a candidate for each position to be filled and on its reverse side the full text of the election laws; this ballot is returned by noon of November 10, and counted from it the nominees are selected (they being the two receiving the highest vote, for each position) for the final ballot which is mailed to the membership on November 15th. This ballot contains the names of two nominees and a blank space should any member wish to vote for other than one of the nominees presented. The fault with the system lies

with the membership, it is otherwise ideal. Many members of the society ignore the law which is before them and send in defective ballots which have to be thrown out; there seems to be little effort at concerted action, and although the society has well toward 800 members a man who gets 20 votes is pretty certain to be nominated; the major portion of the society does not vote at all, less than 150 voted in the nomination just made and the committee having in charge the count found it no easy matter for the vote was so scattering that it seemed that almost every member of the society was voted for for some one of the sixteen positions to be filled. The scheme is right, but the attitude of the society is all wrong. Those who criticise the official conduct of the society on the ground that it is in the hands of a clique have but to look over the returns at this time to see how easily they might have upset this had they interested themselves, twenty-five votes of uniformity could have made a complete slate which would have occupied a place on the final ballot. What the society needs is not an abandonment of the present excellent election scheme, but some plan by which five or six desirable candidates for each position can be picked out, and these names placed before the membership as a preliminary to the nomination vote, this must be established if we are to have any thing like proper and representative officialdom. President Schwarz has suggested, to this end, that there be district caucuses and that the decision of each district be published in the Bulletin of the society; we would not feel that these caucuses should, of necessity, be limited to districts though that might be a good plan, we feel that any group of members of sufficient size should be allowed the right to voice their wishes. From another source it has been suggested that a page of the Bulletin should be devoted to nomination suggestions, it to be headed with the statement that five (or more) members have signed the suggestion, and under the various headings the names as received be entered without further comment, there is no occasion for eulogistic argument, or for an enumeration of sponsors. Certainly something must be done to concentrate the attention of the society in this matter; in the random manner now prevalent the nominees on the ballot are not of necessity there because of any particular degree of fitness, nor because they are the choice of any considerable number of the membership, nor because it is know that they really desire or intend to serve.

The Profession's Attitude Toward Innovations.

While it is generally conceded that the medical profession errs, if error it may be called, on the side of conservatism in the matter of radical discoveries or presumed discoveries; there occur, just often enough to keep us humble, occasions when methods and agents are exploited as something revolutionizing which are presently relegated to the oblivion from which they should never have gained an exit. Such an experience makes the profession slow to grant recognition to anything in the line of a radical innovation and is one cause for lay impatience with us. It has been said, and we believe truthfully, that the higher specialized a man is the more readily he accepts innovations, that he is always so interested in the new that he fails to realize what he has abandoned. Certain it is that the profession as a whole contents itself with the ultimate results from the laboratories and clinics of those who try out many things with which we never bother ourselves. Sometimes there occurs an innovation in the way of an agent which is so widely heralded that none can remain in ignorance of it, it is backed by men of world-wide repute and nothing reaches the rank and file but words eulogistic of it. The profession has learned to trust certain savants; it is to be hoped that this trust may never be shaken; it will be little short of a calamity if there ever comes a time when there shall be distrust of methods or aims. We are thinking of 606. In so far as the medical press or the profession of America know it is an unalloyed success, reports so remarkable have been published and it has been so exploited as to make it a matter of distress that we have not been able to employ it, patients are demanding it. But we are beginning to hear in a round about way that is not so invariably, universally and eternally a success; no one is claiming that is not a wonderful discovery, but they are beginning to hint that there is a considerable and increasing number of the cases in which it "is not indicated." The try-out here in St. Louis was said to be a brilliant success in those cases in which it was a success; not much is said of the other case or cases. Now 606 has been so widely advertised that our patients are going to demand that we use it; if we decline they will go elsewhere; if we do not have the brilliant result which has been pictured in its lay exploitation who is going to be blamed? It has been so glowingly and uniformly pictured that any deficiency in its action is

bound to be laid to the technique of the physician who has administered it. There is another side to anything which is boosted as has been this remedy and the profession has great call to exercise all its reputed conservatism, both in expression and action, in dealing with it. It is a wonderful discovery, even though it does but a small part of what has been claimed for it. The general adoption should not occur until the try-out period has been satisfactorily long and thorough, and it should then be used only in those cases in which it has been definitely determined that it is indicated. The lay idea that it is going to cure *every* case, and that in a few days, should be definitely discouraged, for it is going to lead to great disappointments.

A Chair of Experimental Pathology to be Founded in the Northwestern University Medical School.—James A. Patten, former board of trade operator, has given $200,000 to found a chair of experimental pathology in the Northwestern University Medical School. The purpose of the chair chiefly is the study of tuberculosis and pneumonia, and the gift was inspired directly by the death from tuberculosis recently of George Patten, brother of the grain operator.

Accidents in New York.—During the month of October seventeen persons were killed and 151 injured on the streets of New York, according to the figures compiled by the National Highways Protective Association. Seven of those killed were children. Automobiles were responsible for the death of eight persons, trolley cars for the death of six. The total number of persons killed on the streets of New York during the ten months ending October 31 was 138, and the total number of injured 811.

The Interstate Federation of Homeopathic Medical Societies of New York and Pennsylvania held its seventh annual session in Binghampton, N. Y., recently, and elected the following officers for the coming year: President, Dr. Reeves B. Howland, of Elmira; first vice-president, Dr. E. M. Cowell, of Athens, Pa.; second vice-president, Dr. Roth, of Wilkesbarre, and secretary and treasurer, Dr. Lynn A. Martin, Binghamton. Dr. Cowell was re-elected as first vice-president. It was decided at the final evening session to hold the next annual meeting of the Federation in Scranton in October, 1911.

SOCIETY PROCEEDINGS

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Thirty-sixth Annual Meeting, held at Detroit, September 13-15, 1910.

(Continued from page 446.)

The Responsibility of Physicians in the Traumatic Neuroses.—Dr. H. H. Drysdale, Cleveland, Ohio: In studying these conditions etiologically I have arrived at the conclusion that the true genesis, in a large majority of cases, is psychic, and that it is fright, fear of death, anticipated pain and anguish received unexpectedly by a totally unprepared sensorium which is the chief element to be considered. Psychologically, fright is a fundmental emotion. Violent in action, it will under certain conditions of mind pervert the sense faculty, disturb the kinesthetic equipose and deform the physical and psychical personality. I consider the manifestations of these conditions to be the involuntary expression of a break in the bodily feeling. These by degrees tend to organize and combine to form a morbid mental state, a delusive conception, as it were, toward which every thought converges. A faulty environment frequently does more harm than the actual injury, as it tends to make the individual introspective and depressed, and as a consequence he throws aside the normal weapons of defense and surrenders himself to the misfortune which has assailed him. From an experience of 108 cases investigated from the standpoint of the corporation as well as that of the patient, and which included in many instances the prelitigation, also the postlitigation period, I have made several observations which I believe, if put into practice, would place the responsibility of adjusting these trying conditions on a scientific basis, and thus obliterate much of the confusion and disquietude which surrounds the traumatic functional disorders of the nervous system.

Hygroma of the Testicle.—Dr. Charles M. Harpster, Toledo, Ohio: A hygroam is essentially a serous cyst. The bacillus of tuberculosis is often found, and the hygroma, if a true one, always contains hard caseous masses and rice bodies. A true hygroma of the testicle and cord is rare. In the case of a man, aged 45, the patient suffered from a hydrocele for a number of years, and this was frequently tapped by his family physician. Some months ago it was tapped and considerable blood and some pus were withdrawn. This alarmed the

patient, and in consultation with the attending physician I found the testicle considerably enlarged and very painful, with some slight general disturbance. The cord and testicle were removed. Tubercle bacilli were found in the rice bodies and tissue of the sac. Syphilis undoubtedly had been contracted, but was denied by the patient.

The Tubercle Bacilli Cultivated from Cases of Primary Tuberculous Cervical Adenitis.—Dr. William Litterer, Nashville, Tenn.: Nine consecutive cases of primary tuberculous cervical adenitis were examined, which resulted in the isolation of five cultures of bacillus tuberculosis of the human type, and the four cultures of the bovine type. The classification of the types being made on the basis of our tests, to wit: First, the morphologic characters of the bacilli; second, the dysgenetic or eugenetic characters of the cultures; third, the relative virulence toward rabbits, and, fourth, the reaction curve in 5 per cent glycerin bouillon. The latter test serves admirably to distinguish between the two types, provided repeated application and careful control over a period, in some instances, of 18 months. I have found that the differences in the growth of the two types dysgenetic and eugenetic on Dorcet's egg medium to be very valuable in differentiating the bovine from the human type of bacillus. Rabbit virulence has probably been more uniformly satisfactory than any of the tests in determining the differences between the two types of bacilli.

President's Address: Teaching of Clinical Psychiatry; A Medical Educational Problem.—Dr. Frank P. Norbury, Hospital, Ill.: The opportunities at hand should be utilized, new ones developed, higher ideals created, and ethical educational standards readjusted. The fundamental fact of the present controversy regarding medical education is that it is a part of the educational propaganda of the century—a world movement. In this country, guided in constructive analysis in medical education by the Council on Medical Education of the American Medical Association, this progress is based first on the integration of the educational system; second, on the standardizing of undergraduate work; third, on the standardizing of professional courses in medicine. A virile contributory constructive power is the report of the Carnegie Foundation for the Advancement of Teaching. Modern medical education is in the transitory stage in teaching clinical medicine. This transition began with Osler's work at Johns Hopkins when he demonstrated that "teaching hath her victories no less than research." Clinical medicine today includes the interpreters as well as the research workers. Medical sociology is the enlarged appreciation of the value of clinical medicine extended to the problems of etiology, preventive medicine, occupational diseases, and general and special civic problems. The scope and value of such work is unappreciated by the unthinking masses of our profession. Clinical psychiatry is prominent in this field of newer clinical activity. It is in contact with more points in life, its realities, its ignorance, its prejudices, its ethical discordances, and falsifications, than any other department of medicine. The teacher must be a biologist in its widest clinical interpretation, a sociologist that he may grasp all etiologic factors, and an internist that he may be in touch with all of the physical factors entering into the problem. Modern medical teaching must give to the student the opportunity to see the whole at near range. The teaching of psychiatry is a state need, just as much as any other problem of preventive medicine.

Address in Surgery: Diagnosis of Surgical Lesions of the Kidney by the X-Ray and the Cystoscope.—Dr. Louis Frank, Louisville, Ky.: Although the diagnosis of the character of new growths in the kidney may be impossible before operation, the recognition of a surgical lesion and of the surgical indications is not, as a rule attended with great difficulty, provided thorough, painstaking and complete examination of the individual is made. In renal calculus the cystoscope and the radiograph furnish a means for physicial examination which in the presence of even obscure symptoms will render the diagnosis in most cases practically certain. The cystoscopic examination frequently shows a swollen ureteral orifice. The passage of the ureteral catheter will at once show from which kidney the blood or pus in the urine is coming. The cystoscope is not nearly so valuable an aid as the Roentgen ray. It does show whether one kidney alone is involved, or whether or not a kidney has ceased to functionate. As a confirmatory diagnostic means the greatest value of the radiograph is in connection with renal calculi. The predominant signs of most renal affections of a surgical character are pain, hemorrhage, urinary disturbance, and tumor. One or more may be absent, or they may all be present in any given case.

Address in Medicine: The Modern Physician, His Successes, His Failures, His Fu-

ture.—Dr. John K. Mitchell, Philadelphia: A time will come, since the disappearance of all disease is unlikely, when governments will make a more organized contest against it, and will teach and enlist all physicians in a common army as now they educate and pay the soldier. This must come, because with improved sanitation and the constant advance of preventive means, illness will grow infrequent, so that unless he is a paid servant of the state the physician will not be able to exist. When that army is enlisted, the occurrence of preventable disease will be as much a matter for court martial and the punishment of the person who allowed it to pass him as the failure in duty of a soldier asleep at his post. In that golden future in which sickness will be as rare as war is now, instead of being a single hand fighter, the physician will serve as an enlisted man in the great battle for life and strength against illness and pain; he will have no new duties, perhaps, but new powers—ability to enforce obeidence to laws of health—until, under wise ways of life, death, the one unmedicinable disease, shall come only to the aged, approaching without notice, to be met without fear, bringing an ending peaceful and calm after an active life and a quiet old age.

Pulmonary Tuberculosis and Syphilis.—Dr. Robert H. Babcock, Chicago, discussed the relationship of these diseases and drew the following conclusions: 1. The effect of the association of pulmonary tuberculosis and syphilis seems to depend largely on the stage of the primary disease during which the second infection is acquired. 2. The acquisition of syphilis during the incipient or early period of tuberculosis appears to be of a negative influence or even in some instances to exert a retarding or curative effect on the tuberculosis. 3. Syphilis acquired by a consumptive in an advanced stage is likely to aid the downward progress of tuberculosis. 4. Tuberculosis when developed during the primary or secondary stage of syphilis offers a bad prognosis and is apt to run a rapid course. 5. When pulmonary tuberculosis develops during the third or late stage of syphilis, it is apt to pursue a slow course, probably because of the tendency of the lues to sclerosis during this stage. 6. The association of these two diseases does not preclude the mercurial treatment of the syphilis by intramuscular injections and inunctions, but iodin if administered at all must need be used cautiously because of its tendency to hasten softening of the tuberculous foci. 7. During the antisyphilitic medication there should be relaxation in the hygienic measures recognized as necessary in the management of the tuberculosis.

The Interpretation of Jaundice.—Dr. C. N. Smith, Toledo, Ohio, gave an interpretation of jaundice as observed in gallstone disease and its associated conditions—the interpretation of a symptom which is both infrequency and inconstant, and, at best, indicative only of complications, or terminal events.

DISCUSSION.

Dr. J. H. Carstens, Detroit: Catarrhal jaundice is caused by gastroduodenal catarrh, so called. A patient will have jaundice and in the course of five or six weeks it will disappear, and whether treatment has any effect or not I have grave doubts. I had this form of jaundice myself. I took everything my physicians told me to take —sweet oil ,calomel, and many other things —but the jaundice continued. I then restricted my diet to nitrogenous food, and did not take any carbohydrates, oils, fats, etc., but some good lean beef, some eggs and water, and in a short time the jaundice disappeared.

Dr. R. N. Murray, Flint, Mich.: After suffering from jaundice for a considerable period of time and having tried various remedies, at the request of a Flint physician I took ammonium hydrocholorid in doses of from 10 to 15 grains every 2 hours, and in 4 days the jaundice cleared up.

A New Principle in Treatment of Exophthalmic Goiter.—Dr. G. W. Crile, Cleveland, Ohio: The benefits which follow the ligation of the superior thyroid artery are due for the most part to the break of the nerve supply which is inevitable in the course of the ligation. In exophthalmic goiter the thyroid shows a work hyperplasia, and the brain cells show a work exhaustion. In this condition the brain sends a more or less constant flow of stimuli into the thyroid, and which responds by an increase in its secretion. This increased secretion causes an increased activity of the brain cells. In this manner the brain and the thyroid reciprocally goad each other, and this dead lock, if not broken, continues until one or the other is worn out. This I believe is the explanation of the curious ending one occasionally observes, namely, the sequence of myxedema and exophthalmic goiter. Breaking of the nerves connection between the brain and the thyroid gland renders the disease curable. In no case is a cure effected by operation alone, and no patient is

cured until the thyroid and the brain are both restored to the normal. This is best secured by operating in such a manner that there is no excitation of the nervous system, not of the thyroid gland; hence no volatile outbursts during or after the operation, and no operative danger; the patient should be placed in a rest cure for a month or more, depending on the severity of the disease. If, on the other hand, the patient after the operation is at once immersed in the environment in which the disease originated, there will be many disappointments. The plan of treatment by a combination of a benign operation, followed by a prolonged rest cure, will restore the patient, in so far as tissues are not already irreparably destroyed, to the bloom of health.

Surgery of the Great Sciatic Nerve.—Dr. B. M. Ricketts, Cincinnati, reported two cases of complete severance of this nerve with subsequent anastomosis, and drew the following conclusions: 1. Compression for sciatic neuralgia hardly justifies the effort. 2. Acupuncture with the injection of electricity or medicaments through an open incision is to be recommended. 3. Acupuncture without open incision is most difficult and uncertain to accomplish good results. 4. The use of a metal wire and tube for direct multiple injections should be encouraged. 5. Stretching the nerve for neuralgia has been more or less beneficial, and second in choice before more radical measures are employed. 6. Neurotomy without suture is to be condemned, but it should be employed before sacrificing any of the nerve tissue. 7. Neurectomy is the last of surgical measures to be employed for neuralgia. 8. Neurorrhaphy (primary or secondary) should be done in cases in which the nerve has been partially or completely severed by any cause. 9. The great sciatic nerve may be completely divided and may remain so indefinitely without great loss of sensation. 10. Both sensation and motion may be improved or completely restored by coapting the severed ends with sutures. 11. A small needle and silk are attended with less trauma than those of larger size. 12. Anesthesia may be local or general.

Surgery of Musculospiral Paralysis.—Dr. A. H. Barkley, Lexington, Ky., drew the following conclusions: 1. Many patients have been operated on but comparatively few cases have been reported. 2. In cases of trauma, associated injury of the musculospiral nerve may be and frequently is overlooked. 3. The anatomic position of this nerve renders it peculiarly liable to trauma. 4. Injuries, such as fractures, falls and blows, are the most frequent cause in the order named. 5. The paralysis occurs with equal frequency in both arms, the middle and lower third being the most often affected. 6. The musculospiral nerve is injured oftener than any other nerve and the injury not infrequently serves as ground for legal action. 7. The condition is more frequent in males and may occur at any age, more especially between 10 and 30 years. 8. In cases in which complete loss of sensation and motor function follows severe injury, the probabilities are that the nerve has been injured and operative interference is indicated. In cases following slight trauma the patients often recover without operation; however, if no improvement is noticed fater 2 or 3 months, operation is justified. 9. Secondary cases sometimes present technical difficulties not present in primary cases. 10. No one symptom is pathognomonic and the pathologic condition varies so widely that it is impossible to state before operation with much certainty the exact condition present in a given case. 11. Prognosis is good in clean cases. Especially is this true when operation has been restored too early. One of the most important determining factors is the length of time the injury to the nerve existed. 12. Operative treatment depends on the individual case; the earlier the operation the better the result. Small round needles and fine slik have given best results. 13 All patients with injuries to the arm, especially fractures, should be impressed with the possibility of the development of musculospiral paralysis.

(To be continued)

MEDICAL ASSOCIATION OF THE SOUTHWEST.

Fifth Annudl Meeting, held at Wichita, Kan., October 11-12, 1910.

The President, Dr. G. H. Moody, San Antonio, Texas, in the chair.

Addresses of welcome were delivered by Hon. C. L. Davidson, mayor of Wichita, Dr. O. P. Davis, president of the Kansas State Medical Society, and Dr. E. J. Oldham, of Wichita, Kan., and were responded to by Dr. J. Becton, Greenville, Texas.

Colica Mucosa.—Dr. E. H. Thrailkill, Kansas City, Mo.: I have chosen the designation colica mucosa from the long list of names that have been proposed for non-infectious diseases of the mucous membrane of the colon. It is most appropriate for it designates the passage of mucus and the

attacks of colic. Formerly, this subject was considered a constitutional disease, owing to the lack of scientific knowledge of the etiology and pathology, but in recent years various views and opinions have arisen and have been published. I have adopted the following classification: 1. Those cases due to a motor and sensory neurosis designate as simple colica mucosa. 2. Those due to extra colonic conditions, causing interference with the movement of the fecal discharges, designate as colica mucosa reflexa. 3. Those due to an extension of the inflammatory process from the rectum or appendix, or when due to the retention of hardened fecal masses, foreign bodies, or to the prolonged use of cathartics, causing an inflammatory condition, designate as mucosa colitis. Each class requires a different treatment surgically and medically. In chronic cases, or in those due to a mechanical interference or an inflammatory process, the mucus is thick, tenacious and attended with considerable pain, due to the strong peristalsis of the bowel in its effort to dislodge and expel it. The majority of these patients give a history of disturbed digestion or constipation, preceding the onset of this affection. I have had patients give a history of diarrhea preceding or accompanying this trouble. As a rule, the diarrhea was caused by a diet composed of a concentrated food and the lodgment of fecal crumbs throughout the bowels.

DISCUSSION.

Dr. Arthur E. Hertzler, Kansas City, Mo.: The classification given is very sensible. The difficulty that has arisen in our conception of this disease has been due to confusing the various classes of cases. In some cases the condition is neurotic; in others it is not. We have not used so much care as we should have done in separating the different cases. A patient may present a history of some neurotic condition, and the natural inference is that the trouble is the result of nervous diseases, and yet the disturbance may be secondary to some abdominal lesion which is obscured by the existence of the organic trouble. Unfortunately, we are not in possession of enough knowledge of the abdominal conditions which develop in these nervous states. Most of the cases of colica mucosa I have seen have been in neurotic subjects, who have responded to treatment by the neurologist. There are a number of cases attended by stomach disturbance, and in others by diverticular formations, and yet there is no definite pathologic lesion or defined symptomatology.

Dr. G. W. Robinson, Kansas City, Mo.: My experience with colic mucosa has been confined chiefly to cases among the insane. This condition is more frequent among them than in any other class of patients. Constipation is common among insane patients, and we find that there is a disturbance of the function of the cells of the central nervous system, and I believe this condition is chiefly a perversion of the secretory nerves as well as the motor nerves of the intestine.

Postoperative Care and Treatment of Supubic Prostatectomy.— Dr. D. W. Basham, Wichita, Kan. (see page 455).

DISCUSSION.

Dr. Jabez N. Jackson, Kansas City, Mo.: I am a strong advocate of the perineal route in removing the hypertrophied prostate rather than the suprapubic. In my early practice I resorted to the suprapubic method, but abandoned it subsequently for the perineal, as one of the great difficulties attending the former is the establishment of proper drainage through the suprapubic wound. If I were going to do a suprapubic prostatectomy as a routine measure, I should be inclined to employ the method of Senn, namely, do the operation in two stages, the first stage consisting of making an incision down to and exposing the bladder wall, followed by packing until the cellular space about the bladder is closed by granulations, then making an opening through the bladder. In this way, we do away sometimes with disagreeable infection which takes place in the freshly exposed cellular tissues and which ultimately interferes with the healing of the wound.

Dr. Bransford Lewis, St. Louis: I have always advocated catholicity in connection with this subject and freedom from being restricted to any one operation, still my preference is for the perineal operation in selected cases. I have never been converted to the use of a large tube, such as is used by Freyer and others, because I have not been able to see the advantage of it, particularly when drainage can be accomplished just as effectually and satisfactorily by a smaller tube which will entail a shorter time for convalescence and granulation than a very large tube. The formation of clots can be prevented by the siphonage apparatus of Bremerman, of Chicago.

Dr. E. G. Mark, Kansas City, Mo.: While I favor the perineal route in most cases, yet there are instances in which the

suprapubic is unquestionably the one of choice. The main thing after suprapubic prostatectomy is drainage, and patients with hypertrophied prostate requiring prostatectomy practically always have cystitis. To obviate the occurrence of hemorrhage, to secure efficient drainage, and to do away so far as possible with the formation of clots following cystotomy, nothing in my hands has proved so valuable as continuous irrigation for 24 or 48 hours.

Dr. J. D. Griffith, Kansas City, Mo.: I have done more suprapubic operations than perineal. While I admit the advantages of the perineal route, I think with Freyer that there are many cases in which a suprapubic cystotomy is demanded, and that efficient drainage is the thing par excellence. I believe in irrigating the bladder and in siphonage, and I believe in protecting the space of Retzius with gauze.

Dr. Howard Hill, Kansas City, Mo.: I favor the use of a large tube through the incision after suprapubic prostatectomy, as I believe it is more advantageous than a small one. After the operation, continuous irrigation with hot water, with the patient propped up well and on the side, will control the hemorrhage. Hemorrhage is one of the serious objections to suprapubic prostatectomy, because it occurs from the time the operation is begun, and hemorrhage marks the first stage in the after-treatment of the patient. In regard to suturing around the tube to prevent leakage, one can secure the skin and bladder together.

Dr. G. B. Norberg, Kansas City, Mo.: My experience has been confined largely to operating on these hypertrophied prostates by the perineal route, and I prefer it to the suprapubic operation.

Dr. D. W. Basham, Wichita, Kans.: It is evident that the last word on prostatectomy has has not been said. Each speaker has voiced his own convictions in the matter, and that spirit is to be admired because it is in that way we advance our knowledge. This is an important operation and it behooves us to master all the details connected with it in order that we may increase its safety.

(To be continued)

Dr. Leo Loeb, formerly professor of pathology at the University of Pennsylvania, has taken up his duties as director of the research department of the Barnard Free Skin and Cancer Hospital. He will be assisted by his two former assistants, Drs. Mayer L. Fleisher and O. Ishii.

MEDICAL MISCELLANY

Dr. Lleweylln Williamson, of St. Louis, has re-entered the army service with the rank of major. He is stationed for the present at Fort D. A. Russell, Cheyenne, Wyo.

Obituary.—Dr. John A. Leavy, St. Louis Medical College, 1857, honor member of St. Louis Medical Society, surgeon on General Hardee's staff of the Confederate Army during the Civil War, died at his home, October 24, of apoplexy, aged 76.

Prize to Insane Patient.—An insane woman, a patient in the State Hospital for the Insane at Anoka, Minn., is said to have been recently awarded a prize for the best literary contribution submitted to a certain magazine. Under the circumstances the award, a trip to Europe, was of but little value to the winner, who was, therefore, given a cash prize.

Census of Defective Children.—The Board of Education of Philadelphia has just completed a census of defective children, which shows that there are 573 defective children unable to attend school, said to be about 50 per cent of the actual number in the city, owing to the reluctance of parents to tell of afflictions. The board is advocating a special institution for the care and education of such children. An analysis of the report shows that the largest number of defectives are crippled, the number of cripples being 167.

Birth Registration Propaganda.—Washington, D.C., Nov. 10th, 1910.—At the first meeting of the Advisory Board recently appointed by Health Commissioner Lederle of New York City to prepare recommendation for the improvement of vital statistics in that city, one of the members of which board is Dr. Cressy L. Wilbur, chief statistician for Vital Statistics, of the Bureau of the Census, a recommendation was adopted unanimously to the effect that the most important improvement which could be made in the vital statistics of New York City consists of the verification of the birth registration of every infant dying under 1 year of age, in order to detect omissions, and strict enforcement of the law providing a penalty for an omission to record a birth in every case thus brought to light. New York is one of the few cities in the United States having even an approximately complete registration of births, and this action is likely to result in complete registration and so bring its birth statistics up to the standard found in other countries. The Cen-

sus Bureau is greatly interested in this movement because, as shown in the series of charts prepared for the American Association for Study and Prevention of Infant Mortality, to be held at Baltimore this week, one of the greatest defects of American vital statistics is the entire lose of reliable rates of infant mortality due to defective birth registration.

Opportunities in Cuba.—Cuba with its marvelously rich natural resources is certainly the modern land of opportunity. From its earliest days, and despite the constant drawbacks of an unstable and unsatisfactory government it nevertheless has brought wealth and prosperity to thousands. Since the advent of American brains and business energy, introducing modern machinery and methods of cultivation and transportation, the resources of the island have been developed in a way that is nothing short of marvelous, and yet only the beginning has been made. New capital is needed and excellent investment opportunities are to be found. The International Fruit & Sugar Company, which owns and is developing some of the finest land in the island, is offering through its fiscal agent, the J. L. Rice Company of 45 Milk street, Boston, an allotment of its first mortgage 5 per cent bonds. These bonds carry valuable convertible privileges and form a very attractive as well as safe and profitable investment. They are well worth the investigation of the discriminating investor.

The Treatment of Locomotor Ataxia.—Recognizing the futility of antisyphilitic treatment to materially benefit true cases of ataxia, it occurred to Dr. Graeme M. Hammond several years ago that if we could maintain nutrition of the degenerated cells and maintain the nutrition for a definite length of time that possibly the degenerative process might be arrested or at least delayed. About eight years ago he began treating ataxia with gradually increasing doses of strychnine until doses of ½ grain three times a day, or even more than this, were reached. During this time he treated a great many cases so that he is prepared now to state with some definiteness what this form of treatment has been able to accomplish. In no instance has he ever seen a case of locomotor ataxia cured, but he has seen pains disappear, and control regained over the bladder and bowels, and locomotion decidedly improved. In most all cases the advance of the disease is checked, and a great deal of improvement follows. He has never seen the Argyll-Robertson pupil or the Romberg symptom disappear, nor the knee jerks ever come back, but these symptoms, when present, do not seriously interefere with the patient's life nor materially add to his discomfort; and if we have the means at our disposal of checking the growing ataxia, and even of improving that symptom, of stopping pain, and of giving better control of the bladder and bowels, we are able to do a great deal to alleviate the suffering of a class of patients whom we have not been able to materially benefit heretofore. His method of administering this treatment is as follows: beginning with a dose of 1-30 of a grain three times a day, at the end of a week he increases this dose to 1-20 of a grain; and at the end of another week to a 1-16. These doses are given in tablet form by the mouth. At this time, he gives in addition to the tablet of 1-16 of a grain, one drop of a solution containing one grain of strychnine sulphate to one ounce of water; next day two drops are given; next day three drops, and soon, each day increasing one drop until doses of thirty drops three times a day are reached. As thirty drops of this solution just equal a 1-16 of a grain he is able to discontinue the drops and to substitute for them another tablet containing a 1-16 grain; thus the patient will then take two tablets each containing 1-16 of a grain three times a day or ⅛ of a grain at a dose. The author maintains this dose for three months, then increases the dose with the solution the same as before until a dose of 3-16 is reached. He maintains this dose for at least three months, and then gradually increases as before. In this way the increase in dosage is made so gradually that few patients appreciate any difference. Seldom is any improvement found in a patient's condition until a dose of ¼ of a grain three times a day is reached, though the patient's general health improves long before this period. After a maximum dose of ½ grain is reached it has been the author's custom to maintain this dose for about a year and then to gradually reduce it. He now has patients under observation who have not had any strychnine for over two years, and who show no signs at present of relapsing. In addition to this strychnine treatment the author thinks highly of Frankel's exercises, which seem to do a great deal of good as long as they are kept up, but in the author's experience, as soon as the exercises are discontinued the patient soon loses all the benefit which he derived from their employment.—Therapeutic Medicine.

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A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scentific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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FAVORITE PRESCRIPTIONS

For Gastric Acidity.—Bing (Riforma medica) prescribes the following in the treatment of gastric acidity:

℞ Calcined magnesia.....3i
Lime water.....3ii
Peppermint water.....3ii
Syrup of orange flowers.....3i

M. et sig.: One tablespoonful every two hours.

Ethyl Chloride for Removing Warts.—Dr. Budinger (La Clinique, quoted by L'Union Pharmaceutique) recommends ethyl chloride for the removal of warts. A jet of the liquid is directed upon the wart for one minute and the operation is repeated every two days as long as necessary. A part of wart thus treated falls off, while the remainder shrivels up and gradually disappears, leaving a red spot. Superficial warts disappear readily under this treatment; with deeper ones the outer portion must be excised before applying the ethyl chloride.

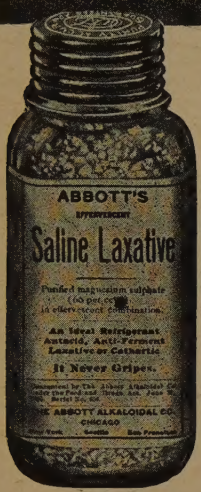
Painful and Perspiring Feet.—Change as often as convenient from one pair of shoes to another. Sponge occasionally with alcohol, or, still better, a five or ten per cent solution of salicylic acid in alcohol. Bathing the feet at night in a solution of permanganate of potassium is also serviceable. A dusting powder composed of alum, boracic acid and talcum is very agreeable. Chilblains are usually relieved by painting with a strong solution of iodine. Corns should be extirpated during the pleasant months of early summer.—Medical Summary.

The Sale of Morphine in New York City will be confined to physicians' prescriptions if the new rule of the Board of Health is carried out to the letter, as intended. The regulations, adopted August 25, require a physician's prescription for morphine in any shape, form, or strength. It is intended to cover everything from morphine alkaloid, to the weakest preparations containing a morphine salt. The operation of this rule will be watched with interest throughout the entire country. Of course it is intended to safeguard the public, but like many well-meant laws, it is likely to defeat the very purpose for which it is intended on account of the difficulty attending its enforcement.

To Preserve Eggs.—A thick paste made of from 2 to 5 parts of casein and 1 to 14 parts of water is mixed with from 2 to 7 parts of ammonia water and a few drops of a solution of salicylic acid, potassium permanganate or some other preservative. For use the paste is considerably diluted. The eggs are allowed to remain for some time in the liquid, becoming gradually covered with a film impenetrable by the air. When the eggs are to be used this film may be removed by washing with 3 to 8 per cent of ammonia water.—Monniteur Scientifique.

Cold Compresses are of Service in Tonsillitis at any age. They are useless if the wet compress is placed around the neck, as it then fails to cover the site of inflammation. It should be be put under the chin and brought around the side of the neck on either side, and to be of sufficient width to cover the peritonsilar area. It is dipped in the cold water and pressed out slightly, quickly applied, and covered with a piece of rubber or oiled silk. It should be renewed every twenty minutes to half hour.

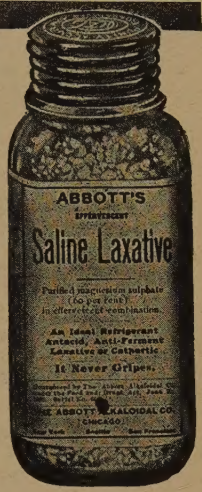
WHAT EVERY NURSE KNOWS



¶ Epsom salt is a good evacuant but has a vile taste, in its ordinary form, which even lemon juice does not conceal. Besides—it frequently upsets the stomach and irritates the intestinal surface to the point of griping.

¶ SALINE LAXATIVE [ABBOTT] affords all its goodness without its vileness and harshness. It represents purified magnesium sulphate (60%) in effervescent combination and yields, with water, a sparkling and refreshing draught no patient will refuse.

¶ It operates quickly and completely—yet gently. It serves best to empty the bowels prior to operation; to correct fecal impaction; to flush out the intestinal tract in infectious cases; and to follow calomel.



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There is no possibility of poisonous effect through the absorption of Listerine.

Listerine Dermatic Soap is a bland, unirritating and remarkably efficient soap. The important function which the skin performs in the maintenance of the personal health may easily be impaired by the use of an impure soap, or by one containing insoluble matter which tends to close the pores of the skin, and thus defeats the object of the emunctories; indeed, skin diseases may be induced, and existing disease greatly aggravated by the use of an impure or irritating soap. When it is to be used in cleansing a cutaneous surface affected by disease, it is doubly important that a pure soap be selected, hence Listerine Dermatic Soap will prove an effective adjuvant in the general treatment prescribed for the relief of various cutaneous diseases.

"The Inhibitory Action of Listerine," a 128-page pamphlet descriptive of the antiseptic, and indicating its utility in medical, surgical and dental practice, may be had upon application to the manufacturers, Lambert Pharmacal Co., Saint Louis, Missouri, but the best advertisement of Listerine is . . . . . .

LISTERINE

MEDICAL MEMORANDA.

The Difference.—"I don't see any difference between you and a trained nurse, dear, except the uniform," said her sick husband.

"And the salary," she added, thoughtfully.—Harper's Bazar.

Throw Back The Invading Host.—Tubercular processes generally seize the favorable opportunity of reduced resistance following a pneumonia or other acute lung disease, to fasten themselves on the patient. In these instances the value of prevention is inestimable. It lies in so charging the tissues with added powers of resistance that tubercular infection is successfully combatted. Not alone by good feeding and right living is this done. The requisite is the selection of a suitable tissue food, a food that is taken up quickly and that adds tone and strength to tissues. Cord. ext. ol. morrhuae comp. (Hagee) for this purpose is not approached. It contains in easily assimulated form the very nutritious elements urgently needed by the depleted tissues to enchant their powers of resistance and give them the strength "to throw back the invading host."

A Restful Abdominal Binder.—There is one very important thing that can be said about the Storm "abdominal binder" that will commend it at once to every physician and that is, it never makes a patient nervous. On the contrary it is common to have patients declare how restful and relieved they feel from wearing "Storm" binders even though they are not conscious that they are on. So many abdominal binders, appendicitis belts, etc., keep patients constantly fretted by the sense of "being harnessed and saddled" as one bright woman described it, that it is a pleasure to recommend the "Storm" binder with its absolute avoidance of unpleasant or "harness-like" effect. The Storm binder is the last word in abdominal supports and the medical profession have been quick to note its superior advantages.—Am. Medicine.

A Swindler Abroad.—Hotels, druggists, physicians, livery men and others, are warned against a man traveling from place to place presenting a card with the name "R. F. Hall" printed in the center. In the lower left hand corner are the words "Parke, Davis & Co.," and in the lower right hand corner the words "Detroit, Mich." This man is described as follows: "5ft. 6 or 8 inches, 150 lbs., fiend for Turkish cigarettes, about 27 years, complexion medium, wears nose glasses and continually takes them off and on; he is a swell dresser, good talker, fine appearance, wears one of those light colored slip on or off rain coats." This individual has no connection with Parke, Davis & Co. and so far as heard uses the card to facilitate the passing of bogus checks. Because of incidents like these nearly all concerns employing "drummers" forbid them to borrow money or seek credit, except upon individual responsibility and acquaintanceship. Therefore, those seeking credit or loans, especially from comparative strangers, on the strength of their alleged connection with some important concern, should be treated as imposters.

Salicylic Acid.—Salicylic acid, especially its sodium salt, has long been recognized as such a reliable cure for acute rheumatism as to be considered a specific. From time immemorial, the bark of salix alba or willow has been used in intermittent fever and even the Hottentots of South Africa have long used an infusion of some species of willow for the cure of rheumatism. It is interesting to observe, therefore, just how salicylic acid acts in rheumatism. There can be no doubt of the fact that rheumatism is caused by some specific micro-organism and that in various articular affections the microbes, when they obtain access to the body, find a suitable nidus in synovial membranes and we know that besides the active forms, other hybrid forms of pseudo-rheumatisms can be distinguished which are also due to organisms gaining entrance into the joints, such as gonococcus, pneumococcus, staphylococcus, etc. In addition to the pronounced antiseptic action of salicylic acid it possesses antithermic, analgesic, chologogic and eliminative properties. Besides there are few drugs in the pharmacopeia which can excel sodium salicylate from the natural oil in its action on the liver, for it stimulates this organ to increased activity, causing a greater flow of the bile, which is rendered more watery and is at the same time excreted under a higher pressure. But one should always use the salicylic acid obtained from natural sources, since this acid has the great advantage of not being a depressant and gives much better results, because it does not contain any of the impurities of the artificial product. Natural salicylic acid is the remedy par excellence in rheumatism and in fact the micro-organism of acute rheumatism is just as sensitive to natural salicylic acid as that of syphilis to mercury or that of malaria to quinine. Although not as a specific as in rheumatism, but as an antiseptic and analgesic, the use of salicylic acid in many other forms of local inflammation, such as tonsillitis, urethritis, orchitis, etc., gives satisfactory results, relieving both pain and distress. Tongaline not only possesses all the therapeutic properties of salicylic acid from the natural oil, but on account of its other ingredients has a much wider field of usefulness, and is unequaled as an efficient and reliable agent in the treatment of rheumatism, neuralgia, grippe, gout, nervous headache, sciatica, lumbago, malaria, tonsillitis, heavy colds and excess of uric acid.—The Chicago Medical Recorder, September, 1910.